IN THE UNITED STATES PATENT AND TRADEMARK OFFICE
Before the Board of Patent Appeals and Interferences

Applicants   : M. Balogh

Serial No.   : 10/608,254

Filed   : June 27, 2003

For   : A System for Processing Unpaid Healthcare Claims

Examiner   : Sheetal Rangrej

Art Unit   : 3626

APPEAL BRIEF

May It Please The Honorable Board:

Appellants initiate a new appeal under 37 CFR 41.27 in response to the Final Rejection, dated May 3, 2007, of Claims 1 - 17 of the above-identified application. The fee of five hundred dollars ($500.00) for filing this Brief is to be charged to Deposit Account No. 19-2179. Enclosed is a single copy of this Brief.

Please charge any additional fee or credit any overpayment to the above-identified Deposit Account.

Appellants do not request an oral hearing.

I.   REAL PARTY IN INTEREST

The real party in interest of Application Serial No. 10/608,254 is the Assignee of record:

Siemens Medical Solutions Health Services Corporation

51 Valley Stream Parkway

Malvern, PA 19355-1406

which merged into Siemens Medical Solutions USA Inc. on 1 January 2007

II.   RELATED APPEALS AND INTERFERENCES

There are currently, and have been, no related Appeals or Interferences regarding Application Serial No. 10/608,254.

III.   STATUS OF THE CLAIMS

Claims 1 - 17 are rejected and the rejection of claims 1-17 are appealed.

IV.   STATUS OF AMENDMENTS

All amendments were entered and are reflected in the claims included in Appendix I.

V.   SUMMARY OF CLAIMED SUBJECT MATTER

Independent claim 1 describes a method for processing claim data for reimbursement of provision of healthcare to a patient in response to rejection, denial or lack of response to a submitted claim (page 3, lines 3-24 and page 4, lines 1-3). An internal activity code (page 9, lines 11-27 and Fig. 1, reference no. 108) is automatically selected from a predetermined internal activity code set specific to a particular organization and including a plurality of codes identifying processing to be performed concerning rejected claim data in response to a received notification of claim denial or rejection (page 4, lines 3-6). The selected internal activity code is automatically assigned to rejected claim data associated with the received notification (page 4, lines 6-7). A task is automatically scheduled (page 4, lines 7-11). The task includes performing processing concerning the rejected claim data to derive corrected claim data including at least one of claim data supplemental to the rejected claim data and amended rejected claim data in response to the assigned selected internal activity code (page 18, lines 11-14). The corrected claim data is prepared by including a standard activity code (page 6, lines 22-25; Fig. 1, reference no. 109 and Fig. 10) from a standard activity code set different to the internal activity code set and facilitating compatible communication between the particular organization and payer organization for submission to the payer organization for payment (page 4, lines 10-11).

Dependent claim 2 includes the features of independent claim 1, along with the additional feature that the predetermined internal activity code set is different from a set of codes identifying a nonpayment reason associated with the rejected claim data including at least one of, a rejection reason (page 18, lines 30-32 and Fig. 7, reference no. 701), a rejection activity code representing the rejection reason (page 19, lines 3-7 and Fig. 7, reference no. 701), a denial reason (page 20, lines 21-22 and Fig. 9, Reference no. 901) and a denial activity code (page 20, line 30-page 21, line 3 and Fig. 9, reference no. 902) representing the denial reason.

Dependent claim 3 includes the features of independent claim 1, along with the additional step of receiving a nonpayment code including at least one of, a rejection code and a denial code (page 14, lines 26-27 and Fig. 1, reference no. 108) associated with the rejected claim data and the selecting step includes interpreting the received nonpayment code (page 8, line 31-page 9, line 1) to determine, from the predetermined internal activity code set, an internal activity code compatible with the nonpayment code (page 9, lines 20-27).

Dependent claim 4 includes the features of independent claim 1, along with the additional step of receiving a nonpayment code of a nonpayment code set including at least one of, a rejection code and a denial code (page 14, lines 26-27 and Fig. 1, reference no. 108) associated with the rejected claim data. The steps of interpreting the received nonpayment code (page 8, line 31-page 9, line 1) and translating the interpreted received nonpayment code to the standard activity code compatible with the standard activity code set are included.

Dependent claim 5 includes the features of independent claim 1, along with the additional step of translating the interpreted received nonpayment code to an internal activity code (page 9, lines 19-20). The internal activity code set includes fewer codes than the predetermined nonpayment code set.

Dependent claim 6 includes the features of independent claim 1, along with the additional step of assigning a time and date identifier to rejected claim data associated with the received notification (page 14, lines 30-32). The identifier indicating a time and date is indicative of at least one of a time and date associated with scheduling a task including performing processing concerning the rejected claim data; a time and date associated with processing the received notification of claim denial or rejection; a time and date associated with receiving notification of claim denial or rejection and a time and date identifying expiration of a period assigned to complete performance of the processing concerning the rejected claim data (page 14, line 32-page 15, line 8 and Fig. 4, reference no. 408).

Dependent claim 7 includes the features of independent claim 1, along with the additional steps of assigning a time and date identifying expiration of a period assigned to complete performance of the processing concerning the rejected claim data (page 15, lines 14-20) and initiating generation of a message alerting a user to at least one of, the period is due to expire at the time and date and the period has expired (page 15, lines 5-8).

Dependent claim 8 includes the features of independent claim 1, along with the additional feature that the method is used to provide corrected claim data for a plurality of rejected claims in response to a corresponding plurality of received notifications of claim denial or rejection (page 18, lines 12-14). The step of collating data concerning the rejected claims by at least one of payer organization associated with the notification and reason for claim rejection or denial derived from the notification is included (page 18, lines 6-11 and Fig. 7).

Dependent claim 9 includes the features of independent claim 1, along with the additional feature that the method is used to provide corrected claim data (page 4, lines 10-11) for a plurality of rejected claims in response to a corresponding plurality of received notifications (page 7, lines 21-24). The step of automatically collating rejected claim data by at least one of payer organization associated with the notification, assigned activity code (page 4, lines 6-7) and type of request for information indicated in a corresponding notification is included.

Dependent claim 10 includes the features of independent claim 1, along with the additional step of acquiring statistics concerning at least one of, type and frequency of claim rejections, type and frequency of claim denials, data identifying success rate of first time claims submissions for an individual payer, data indicating a time duration expected for processing of a submitted claim for an individual payer, data indicating a time duration expected for processing a non-paid claim until resubmission and data identifying a proportion of non-recoverable claims for an individual payer (page 10, line 23-page 11, line 3).

Dependent claim 11 includes the features of independent claim 1 and 10, along with the additional step of employing the statistics to at least one of, modify processing of the rejected claim data and create a statistical report for an individual payer (page 12, lines 4-7).

Dependent claim 12 includes the features of independent claim 1, along with the additional step of determining from the notification whether the rejected claim data was accompanied by a denial or rejection notification and the selecting step includes selecting a

4

first internal activity code in response to a denial notification and a different second internal activity code in response to a rejection notification (page 8, lines 3-28 and Fig. 9).

Dependent claim 13 includes the features of independent claim 1, along with the additional feature that the method steps are performed automatically and at least one of, excluding manual intervention and employing partial manual intervention by one or more healthcare workers (page 5, lines 26-28).

Independent claim 14 provides a method for processing claim data for reimbursement of provision of healthcare to a patient in response to rejection, denial or lack of response to a submitted claim (page 3, lines 3-24 and page 4, lines 1-3). A nonpayment code is identified (page 14, lines 26-27) and is associated with a predetermined nonpayment code set, from a received notification of claim nonpayment associated with particular claim data. An internal activity code (page 9, lines 11-27 and Fig. 1, reference no. 108) is automatically selected from a predetermined internal activity code set including a plurality of codes specific to a particular organization (page 4, lines 10-11). Processing to be performed concerning non-paid claim data is identified in response to the identified nonpayment reason (page 9, lines 20-24). The selected internal activity code is automatically assigned to the particular claim data associated with the received notification (page 4, lines 6-7). A task is automatically added to a task list of a worker including performing processing concerning the particular claim data to derive corrected claim data including at least one of, claim data supplemental to the rejected claim data and amended rejected claim data (page 18, lines 12-14), in response to the assigned selected internal activity code (page 18, lines 11-14). The corrected claim data is prepared by including a standard activity code from a standard activity code (page 6, lines 22-25; Fig. 1, reference no. 109 and Fig. 10) set different to the internal activity code set and facilitating compatible communication between the particular organization and a payer organization for submission to the payer organization for payment (page 4, lines 10-11).

Dependent claim 15 includes the features of independent claim 14, along with the additional feature that the identified nonpayment code includes at least one of, a rejection code and a denial code associated with the particular claim data (page 14, lines 26-27 and Fig. 1, reference no. 108). The selection step includes the identified nonpayment code (page 8, line 31-page 9, line 1) to determine, from the predetermined internal activity code set, an internal activity code compatible with the nonpayment code (page 9, lines 20-27).

Dependent claim 16 includes the features of independent claim 14, along with the additional feature that the predetermined nonpayment code set is compatible with a HIPAA standard code set (page 9, lines 15-18 and Fig. 1, reference no. 109).

Independent claim 17 provides a system for processing claim data for reimbursement of provision of healthcare to a patient in response to rejection, denial or lack of response to a submitted claim (page 3, lines 3-24 and page 4, lines 1-3). A workflow processor is included (page 6, lines 20-28) for automatically selecting an internal activity code (page 9, lines 11-27 and Fig. 1, reference no. 108) from a predetermined internal activity code set specific to a particular organization and including a plurality of codes identifying processing to be performed concerning rejected claim data in response to a received notification of claim denial or rejection (page 4, lines 3-6). The selected internal activity code is automatically assigned to rejected claim data associated with the received notification (page 4, lines 6-7). A task is automatically added to a task list of a worker (page 19, lines 1-3) including performing processing concerning the rejected claim data to derive corrected claim data including at least one of, claim data supplement to the rejected claim data and amended rejected claim data (page 18, lines 12-14), in response to the assigned selected internal activity code (page 18, lines 11-14). An interface processor prepares the corrected claim data by including a standard activity code from a standard activity code (page 6, lines 22-25; Fig. 1, reference no. 109 and Fig. 10) set different to the internal activity code set and facilitates compatible communication between the particular organization and the payer organization for submission to a payer organization for payment (page 4, lines 10-11).

VI.   GROUNDS OF REJECTION TO BE REVIEWED ON APPEAL

Claims 4 and 12 are rejected under 35 USC 112, second paragraph as being indefinite for failing to particularly point out and distinctly claim the subject matter which Applicant regards as the invention.

Claims 1, 2, 12-14, 16 and 17 are rejected under 35 USC 103(a) as being unpatentable over Provost et al. (U.S. Patent No. 6,341,265) in view of Pritchard (U.S. Patent No. 4,491,725).

Claims 3-5 and 15 are rejected under 35 USC 103(a) as being unpatentable over Provost et al. (U.S. Patent No. 6,341,265) in view of Giannini (U.S. Patent No. 5,915,241), and further in view of Pritchard (U.S. Patent No. 4,491,725).

Claims 6-11 are rejected under 35 USC 103(a) as being unpatentable over Provost et al. (U.S. Patent No. 6,341,265) in view of Diamant et al. (U.S. Patent No. 5,530,861), and further in view of Pritchard (U.S. Patent No. 4,491,725).

VII.   ARGUMENT

Applicant respectfully submits that claims 1-17 satisfy the requirements set forth in 35 USC 112, second paragraph and fully particularly point out and distinctly claim the subject matter which Applicant regards as the invention. Provost does anticipate the present claimed invention.   Additionally, Provost, when in any combination with Pritchard, Giannini and Diamant does not make the present claimed invention unpatentable. Thus, reversal of the Final Rejection (hereinafter termed "rejection") of claims 1-17 under 35 U.S.C. § 112, second para. and 103(a) is respectfully requested.

Rejection of Claims 4 and 12 under 35 USC 112, second paragraph

Claims 4 and 12 are rejected under 35 USC 112, second paragraph as being indefinite for failing to particularly point out and distinctly claim the subject matter which applicant regards as the invention.

The Office Action on page 2 argues that "[t]he examiner is unable to determine the difference between a nonpayment code and a standard activity code, because the specification defines the standard activity code referred to as a predetermined nonpayment activity code." Applicant respectfully submits that although the definition of standard **activity** code does encompass nonpayment **activity** code (see page 8, lines 31-32) and may represent a nonpayment code (see page 7, lines 5-7), a standard **activity** code is not the same as "a nonpayment code" as recited in claim 4 of the present invention. The claim 4 embodiment recites a nonpayment code and not a nonpayment **ACTIVITY** code. A nonpayment code is not the same as a nonpayment **activity** code because the nonpayment code (as recited in claim 4) is interpreted and translated, as shown in the present claimed invention and the claim 4 recitation.   Specifically, claim 4 recites "interpreting said received **nonpayment code,** translating said interpreted received **nonpayment code** to said standard activity code compatible with said standard activity code set." Thus, the claim 4 embodiment recites translating the INTERPRETED received nonpayment code to the standard activity code (see Fig. 10) compatible with the standard activity code set. Therefore, in view of the above remarks, Applicant respectfully submits that this rejection with respect to claim 4 is satisfied and should be withdrawn.

The Office Action on page 3 rejects claim 12 because "the examiner is unable to determine how the rejected claim data could be accompanied by a denial notification." Applicant respectfully submits that the claim 12 recitation includes "the step of determining from said notification whether said rejected claim data was accompanied by a denial or rejection notification." Thus, it is determined from the notification whether the rejected claim data was accompanied by a denial or rejection notification. Further, there is no

inconsistency in claim 12 and Applicant does not understand the rejection with respect to claim 12. Specifically, as cited by the Office Action, page 8, lines 14-19 of the Specification states that

> "[t]he difference between denials and rejections is that the payer absolutely will not pay on the payment request for a denial, and that the payer may pay on the payment request for a denial, and that the payer may pay on the payment request for a rejection if the reason for the rejection is corrected. Hence, rejections and denials are segregated by the cashier unit 102, and assigned to the rejection unit 103 or the appeal unit 104 for further investigation and processing."

Thus, a payer absolutely will not pay on the payment request for a denial, which is different from a rejection, in which the payer MAY pay on the payment request for a rejection if the reason for the rejection is corrected. Therefore, Applicant respectfully submits the "rejected claim data" can be "accompanied by a denial or rejection notification" as recited in claim 12 of the present claimed invention.

In view of the above remarks, Applicant respectfully submits that this rejection is satisfied and should be withdrawn.

Rejection of Claims 1, 2, 12-14, 16 and 17 under 35 U.S.C. 103(a) over Provost et al. (U.S. Patent No. 6,341,265) in view of Pritchard (U.S. Patent No. 4,491,725)

Reversal of the rejection of claims 1, 2, 12-14, 16 and 17 under 35 U.S.C. 103(a) as being unpatentable over Provost et al. (U.S. Patent No. 6,341,265) in view of Pritchard (U.S. Patent No. 4,491,725) is respectfully requested because the rejection makes crucial errors in interpreting the cited reference. The rejection erroneously states that claims 1, 2, 12-14, 16 and 17 are made unpatentable over Provost in view of Pritchard.

Overview of the Cited References

Provost describes methods and systems for interactively creating and submitting insurance claims and determining whether the submitted claims are in condition for payment by an insurer. A medical technician operating a client computer establishes communication with a remote server. The remote server transmits a claim form to the client computer for display to the medical technician. Using the claim form, the technician enters patient identification information, which is transmitted to the server to determine whether the patient is a beneficiary of an approved insurance plan. If the patient is a beneficiary, the technician can prepare an insurance claim using the claim form displayed by the client computer. The

technician enters a diagnosis code and a treatment code representing the diagnosis and treatment of the patient. The diagnosis and treatment codes are transmitted to the remote server, which processes the codes to determine whether the claim corresponds to health care services that are approved for payment. If the insurance claim is not in condition for payment, the medical technician is notified. The medical technician can then amend the insurance claim as necessary and resubmit the claim (see Abstract).

Pritchard describes a medical claim verification and processing system that reads a medical information card (MEDICARD) to determine a patient's background medical and insurance information. The validity of the card is rapidly determined by accessing a central brokerage computer. A local service provider enters into a local terminal the medical and MEDICARD information services provided or to be provided to the patient by using a patient service code and transmits this information to a central brokerage computer. The central brokerage computer converts the patient service code input by the service provider or MEDICARD into a particular service code for the patient's insurance carrier. This service code is then utilized to determine the insurance claim payment for that particular patient service. The claim payment amount for the medical service is then transmitted back to the local entry terminal for use by the service provider and patient. The service provider and patient can then determine the amount of payment which will be made for the particular insurance claim. The provider can then prepare an electronic claim form and, together with the patient's and/or the provider's determination whether or not the assignment provision of the insurance claim will be invoked, the electronic claim form is then transmitted to a central brokerage computer which in turn transmits the claim form to the appropriate insurance carrier. The patient's insurance carrier processes the claim form, and, based upon the assignment decision, transfers the payment check to the patient or makes an electronic funds transfer to an account for the service provider, the patient or a central brokerage computer (see Abstract).

In rejecting claims under 35 U.S.C. § 103, it is incumbent upon the examiner to establish a factual basis to support the legal conclusion of obviousness. *In re Fine*, 837 F.2d 1071, 5 USPQ2d 1596, 1598 (Fed.Cir. 1988). In so doing, the Examiner is expected to make the factual determinations set forth in *Graham v. John Deere Co.*, 383 U.S. 1, 17, 148 USPQ 459, 467 (CCPA 1966), and to provide a reason why one having ordinary skill in the pertinent art would have been led to modify the prior art or to combine prior art references to arrive at the claimed invention. Such reason must stem from some teaching, suggestion, or implication in the prior art as a whole or knowledge generally available to one having ordinary skill in the art. *Uniroyal, Inc. v. Rudkin-Wiley Corp.*, 837 F.2d 1044, 1051, 5 USPQ2d 1434, 1438 (Fed.Cir. 1988), *cert. denied*, 488 U.S. 825 (1988); *Ashland Oil Inc. v.*

Delta Resins & Refractories, Inc., 776 F.2d 28, 293, 227 USPQ 657, 664 (Fed.Cir. 1985), *cert. denied*, 475 U.S. 1017 (1986); *ACS Hosp. Sys., Inc. v. Montefiore Hosp.*, 732 F.2d 1572, 1577, 221 USPQ 929, 933 (Fed.Cir. 1984). These showings by the Examiner are an essential part of complying with the burden of presenting a *prima facie* case of obviousness. *In re Oetiker*, 977 F.2d 1443, 1445, 24 USPQ2d 1443, 1444 (Fed.Cir. 1992).

CLAIMS 1 and 13

Claim 1 provides a method for processing claim data for reimbursement of provision of healthcare to a patient in response to rejection, denial, or lack of response to a submitted claim. An internal activity code is automatically selected from a predetermined internal activity code set specific to a particular organization and includes a plurality of codes identifying processing to be performed concerning rejected claim data in response to a received notification of claim denial or rejection. The selected internal activity code is automatically assigned to rejected claim data associated with the received notification. A task is automatically scheduled. The task includes performing processing concerning the rejected claim data to derive corrected claim data including at least one (a) claim data supplemental to the rejected claim data and (b) amended rejected claim data, in response to the assigned selected internal activity code. Corrected claim data is prepared by including a standard activity code from a standard activity code set different to the internal activity code set and facilitating compatible communication between the particular organization and a payer organization for submission to the payer organization for payment. These features are not shown (or suggested) by Provost in view of Pritchard.

The method of claim 1 provides an automated workflow processing system for use in obtaining reimbursement for a claim for a previously provided healthcare service that has been rejected, denied or has not yet received a response. The claimed system maximizes the number of payment requests that are paid whilst minimizing the amount of time spent by employees in attempting to follow-up with payer organizations to obtain payment for services rendered (Application, page 3, lines 11-24). The claimed method automatically selects "internal activity codes" from a set of codes that is "specific to a particular organization" and also includes codes relating to "processing to be performed concerning rejected claim data" when the system is notified that the claim has been rejected or denied. The "internal activity code" is automatically assigned to the "rejected claim data" and the "internal activity code" indicates a task relating to further processing of the "rejected claim data" that is scheduled in response to the "internal activity code." This advantageously allows for preparation of "corrected claim data" which includes "a standard activity code from a standard activity code set different from said internal activity code set and facilitating **compatible communication** between said particular organization and a payer organization."

The use of an "internal activity code" in combination with a "standard activity code" in preparing "corrected claim data" increases system efficiency.

In contrast to the claimed invention, Provost (with Pritchard) neither discloses nor suggests the use of an "internal activity code" to **automatically** schedule internal workflow processing, including automatic task scheduling, for use in preparing "corrected claim data." Furthermore, Provost neither discloses nor suggests using a "standard activity code" that is different from the "internal activity code" to facilitate "compatible communication between" a payer organization and a payee organization as in the present claimed invention. Rather, Provost describes a system for creating and approving a health insurance claim whereby a user of client computer is able to interactively create and communicate a claim with a server which provides immediate feedback informing the user if the claim is in condition to be paid (see col. 1, lines 6-13). Thus, Provost provides a system that is wholly unlike the present claimed system in both objective and operation.

The Rejection states that the "diagnosis code" and "treatment codes" used by Provost are equivalent to the "activity codes" of the present claimed system. Applicant respectfully disagrees. Specifically, col. 6, lines 2-11 of Provost, cited by the Rejection, describe a system whereby a user enters a diagnosis code describing a patient diagnosis and treatment code describing a treatment associated with the diagnosis are **manually entered** into the system. The codes used by Provost are not automatically selected, as in the present claimed invention. Additionally, the operation of the Provost system is wholly unlike the claimed arrangement. In Provost, after the diagnosis and treatment codes are manually entered, they are communicated and checked by a remote system to determine if the claim is in condition to be paid. This is wholly unlike the claimed arrangement which "automatically select[s] an internal activity code...**in response to a received notification of claim denial or rejection.**" This is fundamentally different than the Provost system which performs an immediate check to determine if the claim could be paid. Unlike Provost, the claimed method provides an automated workflow process to allow an organization to obtain payment on a claim that has been rejected or denied. The claimed system operates at an entirely different point along the healthcare payment procurement process than the Provost system. The claimed system seeks to facilitate communication between organizations when an initial claim has been rejected or denied whereas Provost attempts to prevent the denial or rejection from occurring in the first place.

Additionally, the "diagnosis codes" and "treatment codes" in Provost are wholly unlike and unrelated to the "internal activity code" and "standard activity code" of the present claimed invention. As discussed above, the diagnosis and treatment codes are manually

11

entered into a sample claim by a user who is treating a patient for communication with a remote claim checking system to determine the likelihood that the claim will be paid. Thus, Provost allows for further manual manipulation of codes or other information should the remote system make a negative determination regarding the claim (see col. 6, lines 13-21). The codes used in Provost are descriptive codes that provide identification of a diagnosis and treatment for a diagnosis. This is entirely unlike and unrelated to both the "internal activity code" and the "standard activity code" used in the present claimed arrangement and thus are not equivalent to one another.

The "internal activity code" is internal to the workflow processing system of an organization and is not needed to be known by an outside organization (see Application, page 9, lines 11-26). This code facilitates further processing using internal codes which are **automatically assigned in response to receipt of a notification of claim denial or rejection.** The codes used by Provost fail to show or suggest the internal activity codes of the claimed invention because the codes in Provost are NOT internal and **must be transmitted to remote systems** and the determination made by the remote system is entirely dependent on either or both of the transmitted diagnosis code and treatment code.

Applicant further respectfully submits that Provost provides no 35 USC 112 compliant enabling disclosure of the activity of "automatically assigning said selected internal activity code to rejected claim data associated with said received notification" as in the present claimed invention. Rather, Provost in col. 4, lines 24-27, discloses transmitting information back to the client including data about why the claim was rejected. Provost fails to disclose assigning a code, in any manner, to rejected claim data. In fact, the Rejection equates the diagnosis and treatment codes as activity codes. Since the codes of Provost are manually entered by a user, the remote system does not and cannot assign diagnosis codes or treatment codes to rejected claim data as the function of the remote system is to determine the state of the manually created claim. Provost would not be able to perform the activities as claimed in claim 1. Transmitting data indicating why a claim is not in condition to be paid does **NOT** suggest "automatically assigning said selected internal activity code to rejected claim data associated with said received notification" as in the present claimed invention.

Provost also fails to provide enabling disclosure of the step of "**automatically scheduling a task comprising performing processing concerning said rejected claim data to derive corrected claim data**" as in the present claimed invention. The Rejection erroneously cites col. 4, lines 27-35 of Provost as disclosing this feature. Rather, the cited section of Provost further defines the information transmitted by the remote system to the client upon determining that a claim is not in proper form for payment. There is no mention of

"scheduling a task" for any purpose. Instead, Provost provides reasons why the claim failed to assist the client in manual correction of the claim form for re-submission thereof. This is not a "task comprising performing processing...to derive corrected claim data" as in the present claimed invention. Furthermore, the claimed step of "automatically scheduling" is performed "in response to said assigned selected internal activity code." Provost fails to provide enabling disclosure of "an internal activity code" for use in automatically scheduling internal workflow processing as in the present claimed invention. Therefore, it is respectfully submitted that this feature is neither disclosed nor suggested by Provost.

Provost also fails to provide 35 USC 112 compliant enabling disclosure or suggest "preparing said corrected claim data by including a standard activity code...different to said internal activity code set and facilitating compatible communication between said particular organization and a payer organization for submission to said payer organization for payment" as recited in the present claimed invention. Rather, the remote server in Provost notifies the client and the client manually changes either or both of the diagnosis and treatment codes in response to information transmitted by the remote system as to why the claim is not in condition for payment (see col. 4, lines 7-35). This is not at all the function performed by the present claimed system. Specifically, Provost does not contemplate two systems that are not able to compatibly communicate with one another. Instead, Provost ensures that claims are in a correct form in response to patient information such as insurance information (see col. 4, lines 15-16).

Unlike Provost, the claimed system advantageously provides a method for process management of activities associated with collecting on unpaid receivable accounts for healthcare enterprises by **automatically** selecting and assigning "internal activity codes" to "rejected claim data" and "automatically scheduling a task...to derive corrected claim data... in response to said assigned selected internal activity code." Corrected claim data is prepared and includes "a standard activity code" from a code set different than the "internal activity code" which facilitates "compatible communication between" a payer and payee organizations. Internal activity codes facilitate leveraging of productivity tools (e.g., contract management, eligibility service, patient identification check) that can automatically gather or verify required information and further increase follow-up specificity, allowing PARs (Patient Account Representatives) to be leveraged across accounts, payers, and facilities to improve claim efficiency. Additionally, the "standard activity codes" expedite routing of claims between institutions and organizations. Provost neither discloses nor suggests a system having the claimed combination of features.

Furthermore, the Rejection on page 4 admits that "Provost does not explicitly teach including a standard activity code from a standard activity code set different to internal activity code set and facilitating compatible communication between a particular organization and a payer organization." However, even if the system of Pritchard was combined with Provost, the combination would not make the present claimed invention unpatentable.

Pritchard describes a medical claim verification and processing system that reads a medication information card (MEDICARD) to determine a patient's background medical and insurance information. Pritchard, when taken alone or in combination with Provost, neither discloses nor suggests the features of the present claimed invention. Specifically, the Rejection cites col. 8, lines 11-52 of Pritchard and argues that the "CPT-IV code" and the "four-digit service code" in Pritchard is equivalent to the standard activity code and the internal code, respectively, in the present claimed invention and Pritchard also facilitates compatible communication through the data terminal. Although the cited passage of Pritchard describes a "CPT-IV code, which was entered by the service provide into the standard form ... converted by use of Table 72 for the appropriate insurance carrier, herein labeled XYZ Mutual" (col. 8, lines 12-16), where "the five digit CPT-IV code [is converted] into a four digit service code for the selected insurance carrier" (col. 8, lines 16-18), the codes are wholly unlike the present claimed invention. The CPT-IV (Current Procedural Terminology) codes "are listed standard patient treatment codes, such as those issued by the AMA" (Col. 5, lines 49-50). Furthermore, "[f]or each of the CPT-IV codes there is listed a corresponding four digit service code for the given insurance carrier. Thus, the standardized AMA CPT-IV code can be converted by means of Table 72 into a specific service code for the given insurance carrier" (Col. 5, lines 51-56). Pritchard may describe converting the CPT-IV code to a four digit code, however, the service code identifies a medical service already performed for a patient and NOT an **activity to be performed** in processing a claim **denial/rejection**, as in the present claimed invention. Thus, Pritchard neither discloses nor suggests "automatically selecting an internal activity code from a predetermined internal activity code set specific to a particular organization and including a plurality of codes identifying processing to be performed concerning rejected claim data in response to a received notification of claim denial or rejection; automatically assigning said selected internal activity code to rejected claim data associated with said received notification" as recited in claim 1 of the present invention. Therefore, as Pritchard neither discloses nor suggests an internal activity code, as in the present claimed invention, Pritchard cannot disclose or suggest "preparing said corrected claim data by including a standard activity code from a standard activity code set different to said internal activity code set and facilitating compatible communication between said particular organization and a payer organization for

submission to said payer organization for payment" as recited in claim 1 of the present invention.

Additionally, even if the systems of Provost and Pritchard were combined, as suggested by the Rejection, the combined system would not make the present claimed invention unpatentable. The combined system would merely yield an interactive system for creating and submitting insurance claims and determining whether the claims are in condition for payment by an insurer. The combined system would include a client computer which establishes communication with a remote server. The combined system would also convert five digit service codes used to identify a service for reimbursement to four digit insurance carrier reimbursement codes. Unlike the present claimed invention which processes denial claim data AFTER billing and rejection/denial, the combined system of Provost and Pritchard occurs **prior to billing**. Furthermore, the combined system does not disclose or suggest "automatically scheduling a task comprising performing processing concerning said rejected claim data to derive corrected claim data including at least one (a) claim data supplemental to said rejected claim data and (b) amended rejected claim data, in response to said assigned selected internal activity code" as recited in claim 1 of the present invention. The combined system does not suggest that an internal code is used to **schedule denial rejection** processing activities at all. The combined system also neither discloses nor suggests the use of an internal code set for automatically assigning the selected internal activity code to rejected claim data associated with the received notifications. The claimed feature of "automatically assigning said selected internal activity code to rejected claim data associated with said received notification," which is neither disclosed nor suggested by the combination, greatly improves claim processing.

Similarly, as described in the above with respect to Pritchard, the combined system of Pritchard and Provost converts a code into a service code which identifies a medical service that was already performed for a patient and NOT an activity to be performed in processing a claim denial/rejection, as in the present claimed invention. Therefore, the combined system of Provost and Pritchard neither discloses nor suggests "automatically scheduling a task comprising performing processing concerning said rejected claim data to derive corrected claim data including at least one (a) claim data supplemental to said rejected claim data and (b) amended rejected claim data, in response to said assigned selected **internal** activity code" as recited in claim 1 of the present invention.

Additionally, the Rejection on page 5 argues that "it is well known in the claims processing art to, automatically or manually, assign diagnostic or procedural claims (i.e. claim data) to internal operation codes or nomenclature specific to an insurance company or hospital

operation." Applicant respectfully disagrees. The automatic selection of an internal activity code, automatic assignment of the selected internal activity code and the automatic scheduling of a task, as in the present claimed invention, is neither disclosed nor suggested by the combined system of Provost and Pritchard. The Rejection further agues that "an appropriate error message, as in Pritchard, is the same as assigning a particular internal code to a rejected claim data. The examiner also interprets that the service provider correcting the form after the error message is sent is the same as a task being scheduled in response to assigned internal activity code (Pritchard, col. 8, 4-52)." Applicant respectfully disagrees. The error message in Pritchard "is sent from a computer 26 via link 22 to the local terminal 20" (col. 8, lines 5-6) upon an error being **detected in a form**. "The server provider 16 can then correct the form and send the corrected form to the central brokerage computer 26. Optionally, the electronic claim form can be evaluated locally without using the computer 26" (col. 8, lines 6-10). Therefore, the error message in Pritchard is created in response to a form being incorrectly prepared and not "meet[ing] the requirements of the patient's insurance carrier" (col. 8, lines 3-4). This is wholly unlike and completely unrelated to "**automatically** assigning said selected internal activity code to rejected claim data associated with said received notification" as recited in claim 1 of the present invention. Nowhere in the cited passage or elsewhere in Pritchard or Provost is there mention or suggestion of the features of the present claimed invention. Additionally, in Pritchard, after an error message is sent, a correct form can be "entered by the service provider ... [in] standard form" (col. 8, lines 13-14). Thus, a service provider can correct an error an erroneous form. However, nowhere in Pritchard or Provost is there any mention or suggestion of "**automatically** scheduling a task comprising performing processing concerning said rejected claim data to derive corrected claim data including at least one (a) claim data supplemental to said rejected claim data and (b) amended rejected claim data, **in response to said assigned selected internal activity code**" as recited in claim 1 of the present invention. Consequently, withdrawal of the rejection under 35 USC 103(a) is respectfully requested.

Dependent claim 13 is considered to be patentable based on its dependence on independent claim 1. Therefore, all arguments presented above with respect to claim 1 also apply to claim 13. Thus, withdrawal of the rejection of claim 13 under 35 U.S.C. 103(a0 is further respectfully requested.

CLAIM 2

Dependent claim 2 is considered to be patentable based on its dependence on claim 1. Therefore, the arguments presented above with respect to claim 1 also apply to claim 2. Claim 2 is also considered to be patentable because Provost in view of Pritchard neither discloses nor suggests that "the predetermined internal activity code set is **different from a set of code**

identifying a nonpayment reason associated with said rejected claim data" as recited in claim 2 of the present invention. Column 10, lines 53-63 of Provost, cited by the Rejection, merely discloses that upon rejecting a claim, the server may transmit a reason for the rejection of the claim. However, as discussed above Provost (with Pritchard) fails to disclose or suggest "an internal activity code" which is used for automatically scheduling internal workflow for a system wherein the "internal activity code" is **different from** "codes identifying a nonpayment reason." Provost merely discloses the latter to function as a check mechanism to ensure the claim is submitted properly in the first place. This is entirely different from the claimed system which controls workflow "concerning rejected claim data in response to a received notification of claim denial or rejection." Furthermore, the codes in Pritchard are merely patient treatment codes that are converted to insurance carrier service codes (see col. 6, lines 47-56 of Pritchard). This is wholly unlike the present claimed invention in which the "predetermined internal activity code set is different from a set of codes identifying a **nonpayment reason** associated with said rejected claim data." Therefore, Provost in view of Pritchard neither discloses nor suggests the features of the present claimed invention. Consequently, withdrawal of the rejection under 35 USC 103(a) is respectfully requested.

CLAIM 12

Dependent claim 12 is considered to be patentable based on its dependence on claim 1. Therefore, the arguments presented above with respect to claim 1 also apply to claim 12. Claim 12 is also considered to be patentable because Provost in view of Pritchard neither discloses nor suggests "determining from said notification whether said rejected claim data was accompanied by a denial or rejection notification and wherein said selecting step comprises selecting a first internal activity code in response to a denial notification and a different second internal activity code in response to a rejection notification" as recited in claim 12 of the present invention.

Provost in view of Pritchard neither discloses nor suggests the use of "internal activity codes" for controlling operation and scheduling of processing to be performed concerning rejected claim data. Furthermore, Provost (with Pritchard) is unable to perform the operation set forth in claim 12 because the activity in the claimed arrangement is performed by a different entity or organization. Specifically, Provost clearly states in the cited section and elsewhere, that the remote system makes the determination regarding claim sufficiency. However, the remote system has no part in assigning codes to anything whatsoever. The remove server of Provost makes a determination of claim sufficiency and provides information to the client if the determination is negative so that the client can alter the claim to be in correct form. This is wholly unlike the present claimed method. In the present claimed invention, the "particular organization" automatically selects "a first internal activity

17

code in response to a denial notification and a different second internal activity code in response to a rejection notification." Provost does not distinguish between rejection and denial because the Provost system aims to prevent an improper claim from being filed in the first place. This is unlike the present claimed invention which distinguishes between "rejection notification" and "denial notification" because they are different responses to a filed claim from a payer organization which may require different further responses from the particular organization. "The difference between denials and rejections is that the payer absolutely will not pay on the payment request for a denial, and that the payer may pay on the payment request for a rejection if the reason for the rejection is corrected. Hence, rejections and denials are segregated by the cashier unit 102, and assigned to the rejection unit 103 or the appeal unit 104 for further investigation and processing." (Application, page 8, lines 14-19). This distinction is not contemplated by Provost (with Pritchard) and therefore Provost in view of Pritchard neither discloses nor suggests handling "rejection notifications" differently than "denial notifications."

Additionally, the Rejection on page 6 admits that "Provost explicitly does not teach a first internal code to a denial notification and as second internal code to a rejection notification." However, Applicant respectfully submits that the Pritchard system, when taken in combination with Provost, also does not disclose or suggest these features. As described in the above with respect to claim 1, the code conversion in Pritchard converts <u>patient treatment codes</u> into insurance carrier service codes. Neither the patient treatment codes nor the converted standard insurance carrier service codes are equivalent to a first and second internal activity code, as in the present claimed invention, where the "selecting step comprises selecting a first internal activity code in response to a **denial notification** and a different second internal activity code in response to a **rejection notification.**" Therefore, the combined system of Provost and Pritchard neither discloses nor suggests determining from said notification whether said rejected claim data was accompanied by a denial or rejection notification and wherein said selecting step comprises selecting a first internal activity code in response to a denial notification and a different second internal activity code in response to a rejection notification" as recited in claim 12 of the present invention.

Furthermore, in the "Response to Arguments" section on page 20 of the Rejection, it is argued that Provost fully supports the limitation of the limitation claim data accompanied by a denial or rejection notification "by showing transmission of information (i.e. notification) to the client computer to inform the medical technician of the result why the submitted claim will not be paid. According to the applicant's definition of a denial or rejection notification, the examiner interprets that the whole claim data was returned to the client with the reasons for denial or rejection of the claim (Provost: column 6, lines 12-15)." Applicant respectfully

submits that the cited passage of Provost merely describes that "[i]f the remote server determines that the submitted claim will not be paid by an insurer, the remote server transmits information to the client computer to inform the medical technician of this result" (col. 6, lines 12-15).   Nowhere in Provost (with Pritchard) is there any mention or suggestion of "determining from said notification **whether** said rejected claim data was accompanied by a **denial** or **rejection notification**" as recited in claim 12 of the present invention. Provost (with Pritchard) merely describes that in the case an insurer refuses to pay a submitted claim, the medical technician is informed. This is wholly unlike the present claimed invention which determines "from said notification whether said rejected claim data was accompanied by a denial or rejection notification." Therefore, Provost in view of Pritchard does not make the present claimed invention unpatentable. Consequently, withdrawal of the rejection under 35 USC 103(a) is respectfully requested.

CLAIMS 14 and 16

Claim 14 provides a method for processing claim data for reimbursement of provision of healthcare to a patient in response to rejection, denial or lack of response to a submitted claim. A nonpayment code is identified and is associated with a predetermined nonpayment code set, from a received notification of claim nonpayment associated with particular claim data. An internal activity code is automatically selected from a predetermined internal activity code set including a plurality of codes specific to a particular organization. Processing to be performed concerning non-paid claim data is identified in response to the identified nonpayment reason. The selected internal activity code is automatically assigned to the particular claim data associated with the received notification. A task is automatically added to a task list of a worker including performing processing concerning the particular claim data to derive corrected claim data including at least one of, claim data supplemental to the rejected claim data and amended rejected claim data, in response to the assigned selected internal activity code. The corrected claim data is prepared by including a standard activity code from a standard activity code set different to the internal activity code set and facilitating compatible communication between the particular organization and a payer organization for submission to the payer organization for payment. These features are not shown (or suggested) by Provost in view of Pritchard.

Contrary to the claimed invention, Provost (with Pritchard) neither discloses nor suggests the use of an "internal activity code" to **automatically** add internal workflow processing, including automatic adding tasks, for use in preparing "corrected claim data." Furthermore, Provost neither discloses nor suggests using a "standard activity code" that is different from the "internal activity code" to facilitate "compatible communication between" a payer organization and a payee organization as in the present claimed invention. Rather,

Provost describes a system for creating and approving a health insurance claim whereby a user of client computer is able to interactively create and communicate a claim with a server which provides immediate feedback informing the user if the claim is in condition to be paid (see col. 1, lines 6-13). Thus, Provost provides a system that is wholly unlike the present claimed system in both objective and operation.

The Rejection states that the "diagnosis code" and "treatment codes" used by Provost are equivalent to the "activity codes" of the present claimed system. Applicant respectfully disagrees. Specifically, col. 6, lines 2-11 of Provost, cited by the Rejection, describe a system whereby a user enters a diagnosis code describing a patient diagnosis and treatment code describing a treatment associated with the diagnosis are **manually entered** into the system. The codes used by Provost are not automatically selected, as in the present claimed invention. Additionally, the operation of the Provost system is wholly unlike the claimed arrangement. In Provost, after the diagnosis and treatment codes are manually entered, they are communicated and checked by a remote system to determine if the claim is in condition to be paid. This is wholly unlike the claimed arrangement which "automatically select[s] an internal activity code... identifying processing to be performed concerning non-paid claim data in response to said **identified nonpayment reason**." This is fundamentally different than the Provost system which performs an immediate check to determine if the claim could be paid. Unlike Provost, the claimed method provides automated workflow process to allow an organization to obtain payment on a non-paid claim that has been identified in response to nonpayment reasons. The claimed system operates at an entirely different point along the healthcare payment procurement process than the Provost system. The claimed system seeks to facilitate communication between organizations when a claim has not been paid due to an identified nonpayment reason. Provost (with Pritchard) on the other hand, does not disclose or suggest these features.

Additionally, the "diagnosis codes" and "treatment codes" in Provost are wholly unlike and unrelated to the "internal activity code" and "standard activity code" of the present claimed invention. As discussed above, the diagnosis and treatment codes are manually entered into a sample claim by a user who is treating a patient for communication with a remote claim checking system to determine the likelihood that the claim will be paid. Thus, Provost allows for further manual manipulation of codes or other information should the remote system make a negative determination regarding the claim (see col. 6, lines 13-21). The codes used in Provost are descriptive codes that provide identification of a diagnosis and treatment for a diagnosis. This is entirely unlike and unrelated to both the "internal activity code" and the "standard activity code" used in the present claimed arrangement and thus are not equivalent to one another.

20

The "internal activity code" is internal to the workflow processing system of an organization and is not needed to be known by an outside organization (see Application, page 9, lines 11-26). This code facilitates further processing using internal codes which are **automatically assigned in response to receipt of a notification of claim denial or rejection**. The codes used by Provost and identified in the rejection as analogous to the activity codes of the claimed invention cannot be equivalent because the codes in Provost **must be transmitted to remote systems** and the determination made by the remote system is entirely dependent on either or both of the diagnosis code and treatment codes.

Applicant further respectfully submits that Provost provides no 35 USC 112 compliant enabling disclosure of the activity of "automatically assigning said selected internal activity code to rejected claim data associated with said received notification" as in the present claimed invention. Rather, Provost in col. 4, lines 24-27, discloses transmitting information back to the client including data about why the claim was rejected. Provost fails to disclose assigning a code, in any manner, to rejected claim data. In fact, the Rejection equates the diagnosis and treatment codes as activity codes. Since the codes of Provost are manually entered by a user, the remote system does not and cannot assign diagnosis codes or treatment codes to rejected claim data as the function of the remote system is to determine the state of the manually created claim. Provost would not be able to perform the activities as claimed in claim 1. Transmitting data including why a claim is not in condition to be paid is **NOT** "automatically assigning said selected internal activity code to rejected claim data associated with said received notification" as in the present claimed invention.

Provost also fails to provide enabling disclosure of the step of "**automatically** adding a task to a task list of a worker comprising performing processing concerning said particular claim data to derive corrected claim data" as in the present claimed invention. The Rejection erroneously cites col. 4, lines 27-35 of Provost as disclosing this feature. Rather, the cited section of Provost further defines the information transmitted by the remote system to the client upon determining that a claim is not in proper form for payment. There is no mention of "adding a task to a task list" for any purpose. Instead, Provost provides reasons why the claim failed to assist the client in manual correction of the claim form for re-submission thereof. This is not a "task list of a worker comprising performing processing concerning said particular claim data to derive corrected claim data" as recited in the present claimed invention. Furthermore, the claimed step of "automatically adding" is performed "in response to said assigned selected internal activity code." Provost fails to provide enabling disclosure of "an internal activity code" for use in automatically adding internal workflow

21

processing as in the present claimed invention. Therefore, it is respectfully submitted that this feature is neither disclosed nor suggested by Provost.

Provost also fails to provide 35 USC 112 compliant enabling disclosure of "preparing said corrected claim data by including a standard activity code...different to said internal activity code set and facilitating compatible communication between said particular organization and a payer organization for submission to said payer organization for payment" as recited in the present claimed invention. Rather, the remote server in Provost notifies the client and the client manually changes either or both of the diagnosis and treatment codes in response to information transmitted by the remote system as to why the claim is not in condition for payment (see col. 4, lines 7-35). This is not at all the function performed by the present claimed system. Specifically, Provost does not contemplate two systems that are not able to compatibly communicate with one another. Instead, Provost ensures that claims are in the correct form in response to patient information such as insurance information (see col. 4, lines 15-16).

Unlike Provost, the claimed system advantageously provides a method for processing the work in process management of activities associated with collecting on unpaid receivable accounts for healthcare enterprises by **automatically** selecting and assigning "internal activity codes" to "rejected claim data" and "automatically adding a task... to derive corrected claim data...in response to said assigned selected internal activity code." Corrected claim data is prepared and includes "a standard activity code" from a code set different than the "internal activity code" which facilitates "compatible communication between" a payer and payee organizations. Internal activity codes facilitate leveraging of productivity tools (e.g., contract management, eligibility service, patient identification check) that can automatically gather or verify required information and further increase follow-up specificity, allowing PARs (Patient Account Representatives) to be leveraged across accounts, payers, and facilities to improve claim efficiency. Additionally, the "standard activity codes" expedite routing of claims between institutions and organizations. Provost neither discloses nor suggests a system having the claimed combination of features.

Furthermore, the Rejection on page 4 admits that "Provost does not explicitly teach including a standard activity code from a standard activity code set different to internal activity code set and facilitating compatible communication between a particular organization and a payer organization." However, even if the system of Pritchard was combined with Provost, the combination would not make the present claimed invention unpatentable.

Pritchard describes a medical claim verification and processing system that reads a medication information card (MEDICARD) to determine a patient's background medical and insurance information. Pritchard, when taken alone or in combination with Provost, neither discloses nor suggests the features of the present claimed invention. Specifically, the Rejection cites col. 8, lines 11-52 of Pritchard and argues that the "CPT-IV code" and the "four-digit service code" in Pritchard is equivalent to the standard activity code and the internal code, respectively, in the present claimed invention and Pritchard also facilitates compatible communication through the data terminal. Although the cited passage of Pritchard describes a "CPT-IV code, which was entered by the service provide into the standard form ... converted by use of Table 72 for the appropriate insurance carrier, herein labeled XYZ Mutual" (col. 8, lines 12-16), where "the five digit CPT-IV code [is converted] into a four digit service code for the selected insurance carrier" (col. 8, lines 16-18), the codes are wholly unlike the present claimed invention. The CPT-IV (Current Procedural Terminology) codes "are listed standard patient treatment codes, such as those issued by the AMA" (Col. 5, lines 49-50). Furthermore, "[f]or each of the CPT-IV codes there is listed a corresponding four digit service code for the given insurance carrier. Thus, the standardized AMA CPT-IV code can be converted by means of Table 72 into a specific service code for the given insurance carrier" (Col. 5, lines 51-56). Pritchard may describe converting the CPT-IV code to a four digit code, however, the service code identifies a medical service already performed for a patient and NOT an activity to be performed in processing a claim denial/rejection, as in the present claimed invention. Thus, Pritchard neither discloses nor suggests "automatically selecting an internal activity code from a predetermined internal activity code set including a plurality of codes specific to a particular organization and identifying processing to be performed concerning non-paid claim data in response to said identified nonpayment reason; automatically assigning said selected internal activity code to said particular claim data associated with said received notification" as recited in claim 14 of the present invention. Therefore, as Pritchard neither discloses nor suggests an internal activity code, as in the present claimed invention, Pritchard cannot disclose or suggest "preparing said corrected claim data by including a standard activity code from a standard activity code set different to said internal activity code set and facilitating compatible communication between said particular organization and a payer organization for submission to said payer organization for payment" as recited in claim 14 of the present invention.

Additionally, even if the systems of Provost and Pritchard were combined, as suggested by the Rejection, the combined system would not make the present claimed invention unpatentable. The combined system would merely yield an interactive system for creating and submitting insurance claims and determining whether the claims are in condition for payment by an insurer. The combined system would include a client computer which

establishes communication with a remote server. The combined system would also convert five digit service codes used to identify a service for reimbursement to four digit insurance carrier reimbursement codes. Unlike the present claimed invention which processes denial claim data AFTER billing and rejection/denial, the combined system of Provost and Pritchard occurs prior to billing. Furthermore, the combined system does not disclose or suggest "automatically adding a task to a task list of a worker comprising performing processing concerning said particular claim data to derive corrected claim data including at least one (a) claim data supplemental to said rejected claim data and (b) amended rejected claim data, in response to said assigned selected internal activity code" as recited in claim 14 of the present invention. The combined system neither discloses nor suggests the use of an internal code set for automatically assigning the selected internal activity code to rejected claim data associated with the received notifications. The claimed feature of "automatically assigning said selected internal activity code to said particular claim data associated with said received notification," which is neither disclosed nor suggested by the combination, greatly improves claim processing.

Similarly, as described in the above with respect to Pritchard, the combined system of Pritchard and Provost converts a code into a service code which identifies a medical service that was already performed for a patient and NOT an activity to be performed in processing a claim denial/rejection, as in the present claimed invention. Therefore, the combined system of Provost and Pritchard neither discloses nor suggests "automatically adding a task to a task list of a worker comprising performing processing concerning said particular claim data to derive corrected claim data including at least one (a) claim data supplemental to said rejected claim data and (b) amended rejected claim data, in response to said assigned selected internal activity code" as recited in claim 14 of the present invention. Consequently, withdrawal of the rejection under 35 USC 103(a) is respectfully requested.

Dependent claim 16 is considered to be patentable based on its dependence on independent claim 14. Therefore, all arguments presented above with respect to claim 14 also apply to claim 16. Thus, withdrawal of the rejection of claim 16 under 35 U.S.C. 103(a) is further respectfully requested.

CLAIM 17

Claim 17 provides a system for processing claim data for reimbursement of provision of healthcare to a patient in response to rejection, denial or lack of response to a submitted claim. A workflow processor is included for automatically selecting an internal activity code from a predetermined internal activity code set specific to a particular organization and including a plurality of codes identifying processing to be performed concerning rejected

claim data in response to a received notification of claim denial or rejection. The selected internal activity code is automatically assigned to rejected claim data associated with the received notification. A task is automatically added to a task list of a worker including performing processing concerning the rejected claim data to derive corrected claim data including at least one of, claim data supplement to the rejected claim data and amended rejected claim data, in response to the assigned selected internal activity code. An interface processor prepares the corrected claim data by including a standard activity code from a standard activity code set different to the internal activity code set and facilitates compatible communication between the particular organization and the payer organization for submission to a payer organization for payment. These features are not shown (or suggested) by Provost in view of Pritchard.

In contrast to the claimed invention, Provost (with Pritchard) neither discloses nor suggests the use of an "internal activity code" to **automatically** add internal workflow processing, including automatic adding, for use in preparing "corrected claim data." Furthermore, Provost neither discloses nor suggests using a "standard activity code" that is different from the "internal activity code" to facilitate "compatible communication between" a payer organization and a payee organization as in the present claimed invention. Rather, Provost describes a system for creating and approving a health insurance claim whereby a user of client computer is able to interactively create and communicate a claim with a server which provides immediate feedback informing the user if the claim is in condition to be paid (see col. 1, lines 6-13). Thus, Provost provides a system that is wholly unlike the present claimed system in both objective and operation.

The Rejection states that the "diagnosis code" and "treatment codes" used by Provost are equivalent to the "activity codes" of the present claimed system. Applicant respectfully disagrees. Specifically, col. 6, lines 2-11 of Provost, cited by the Rejection, describe a system whereby a user enters a diagnosis code describing a patient diagnosis and treatment code describing a treatment associated with the diagnosis are **manually entered** into the system. The codes used by Provost are not automatically selected, as in the present claimed invention. Additionally, the operation of the Provost system is wholly unlike the claimed arrangement. In Provost, after the diagnosis and treatment codes are manually entered, they are communicated and checked by a remote system to determine if the claim is in condition to be paid. This is wholly unlike the claimed arrangement which "automatically select[s] an internal activity code...**in response to a received notification of claim denial or rejection.**" This is fundamentally different than the Provost system which performs an immediate check to determine if the claim could be paid. Unlike Provost, the claimed method provides automated workflow process to allow an organization to obtain payment on a claim that has

been rejected or denied. The claimed system operates at an entirely different point along the healthcare payment procurement process than the Provost system. The claimed system seeks to facilitate communication between organizations when an initial claim has been rejected or denied whereas Provost attempts to prevent the denial or rejection from occurring in the first place.

Additionally, the "diagnosis codes" and "treatment codes" in Provost are wholly unlike and unrelated to the "internal activity code" and "standard activity code" of the present claimed invention. As discussed above, the diagnosis and treatment codes are manually entered into a sample claim by a user who is treating a patient for communication with a remote claim checking system to determine the likelihood that the claim will be paid. Thus, Provost allows for further manual manipulation of codes or other information should the remote system make a negative determination regarding the claim (see col. 6, lines 13-21). The codes used in Provost are descriptive codes that provide identification of a diagnosis and treatment for a diagnosis. This is entirely unlike and unrelated to both the "internal activity code" and the "standard activity code" used in the present claimed arrangement and thus are not equivalent to one another.

The "internal activity code" is internal to the workflow processing system of an organization and is not needed to be known by an outside organization (see Application, page 9, lines 11-26). This code facilitates further processing using internal codes which are **automatically assigned in response to receipt of a notification of claim denial or rejection.** The codes used by Provost and identified in the rejection as analogous to the activity codes of the claimed invention cannot be equivalent because the codes in Provost **must be transmitted to remote systems** and the determination made by the remote system is entirely dependent on either or both of the diagnosis code and treatment codes.

Applicant further respectfully submits that Provost provides no 35 USC 112 compliant enabling disclosure of the activity of "automatically assigning said selected internal activity code to rejected claim data associated with said received notification" as in the present claimed invention. Rather, Provost in col. 4, lines 24-27, discloses transmitting information back to the client including data about why the claim was rejected. Provost fails to disclose assigning a code, in any manner, to rejected claim data. In fact, the Rejection equates the diagnosis and treatment codes as activity codes. Since the codes of Provost are manually entered by a user, the remote system does not and cannot assign diagnosis codes or treatment codes to rejected claim data as the function of the remote system is to determine the state of the manually created claim. Provost would not be able to perform the activities as claimed in claim 1. Transmitting data including why a claim is not in condition to be paid is

NOT "automatically assigning said selected internal activity code to rejected claim data associated with said received notification" as in the present claimed invention.

Provost also fails to provide enabling disclosure of the step of "**automatically** adding a task to a task list of a worker comprising performing processing concerning said rejected claim data to derive corrected claim data" as in the present claimed invention. The Rejection erroneously cites col. 4, lines 27-35 of Provost as disclosing this feature. Rather, the cited section of Provost further defines the information transmitted by the remote system to the client upon determining that a claim is not in proper form for payment. There is no mention of "adding a task to a task list" for any purpose. Instead, Provost provides reasons why the claim failed to assist the client in manual correction of the claim form for re-submission thereof. This is not a "a task list of a worker comprising performing processing concerning said rejected claim data to derive corrected claim data" as recited in the present claimed invention. Furthermore, the claimed step of "automatically adding" is performed "in response to said assigned selected internal activity code." Provost fails to provide enabling disclosure of "an internal activity code" for use in automatically adding internal workflow processing as in the present claimed invention. Therefore, it is respectfully submitted that this feature is neither disclosed nor suggested by Provost.

Provost also fails to provide 35 USC 112 compliant enabling disclosure of "preparing said corrected claim data by including a standard activity code…different to said internal activity code set and facilitating compatible communication between said particular organization and said payer organization for submission to a payer organization for payment" as recited in the present claimed invention. Rather, the remote server in Provost notifies the client and the client manually changes either or both of the diagnosis and treatment codes in response to information transmitted by the remote system as to why the claim is not in condition for payment (see col. 4, lines 7-35). This is not at all the function performed by the present claimed system. Specifically, Provost does not contemplate two systems that are not able to compatibly communicate with one another. Instead, Provost ensures that claims are in the correct form in response to patient information such as insurance information (see col. 4, lines 15-16).

Unlike Provost, the claimed system advantageously provides a method for processing the work in process management of activities associated with collecting on unpaid receivable accounts for healthcare enterprises by **automatically** selecting and assigning "internal activity codes" to "rejected claim data" and "automatically adding a task…to derive corrected claim data…in response to said assigned selected internal activity code." Corrected claim data is prepared and includes "a standard activity code" from a code set different than the "internal

activity code" which facilitates "compatible communication between" a payer and payee organizations. Internal activity codes facilitate leveraging of productivity tools (e.g., contract management, eligibility service, patient identification check) that can automatically gather or verify required information and further increase follow-up specificity, allowing PARs (Patient Account Representatives) to be leveraged across accounts, payers, and facilities to improve claim efficiency. Additionally, the "standard activity codes" expedite routing of claims between institutions and organizations. Provost neither discloses nor suggests a system having the claimed combination of features.

Furthermore, the Rejection on page 4 admits that "Provost does not explicitly teach including a standard activity code from a standard activity code set different to internal activity code set and facilitating compatible communication between a particular organization and a payer organization." However, even if the system of Pritchard was combined with Provost, the combination would not make the present claimed invention unpatentable.

Pritchard describes a medical claim verification and processing system that reads a medication information card (MEDICARD) to determine a patient's background medical and insurance information. Pritchard, when taken alone or in combination with Provost, neither discloses nor suggests the features of the present claimed invention. Specifically, the Rejection cites col. 8, lines 11-52 of Pritchard and argues that the "CPT-IV code" and the "four-digit service code" in Pritchard is equivalent to the standard activity code and the internal code, respectively, in the present claimed invention and Pritchard also facilitates compatible communication through the data terminal. Although the cited passage of Pritchard describes a "CPT-IV code, which was entered by the service provide into the standard form ... converted by use of Table 72 for the appropriate insurance carrier, herein labeled XYZ Mutual" (col. 8, lines 12-16), where "the five digit CPT-IV code [is converted] into a four digit service code for the selected insurance carrier" (col. 8, lines 16-18), the codes are wholly unlike the present claimed invention. The CPT-IV (Current Procedural Terminology) codes "are listed standard patient treatment codes, such as those issued by the AMA" (Col. 5, lines 49-50). Furthermore, "[f]or each of the CPT-IV codes there is listed a corresponding four digit service code for the given insurance carrier. Thus, the standardized AMA CPT-IV code can be converted by means of Table 72 into a specific service code for the given insurance carrier" (Col. 5, lines 51-56). Pritchard may describe converting the CPT-IV code to a four digit code, however, the service code identifies a medical service already performed for a patient and NOT an activity to be performed in processing a claim denial/rejection using a particular workflow, as in the present claimed invention. Thus, Pritchard neither discloses nor suggests "automatically selecting an internal activity code from a predetermined internal activity code set specific to a particular organization and

including a plurality of codes identifying processing to be performed concerning rejected claim data in response to a received notification of claim denial or rejection; automatically assigning said selected internal activity code to rejected claim data associated with said received notification" as recited in claim 17 of the present invention. Therefore, as Pritchard neither discloses nor suggests an internal activity code, as in the present claimed invention, Pritchard cannot disclose or suggest "an interface processor for preparing said corrected claim data by including a standard activity code from a standard activity code set different to said internal activity code set and facilitating compatible communication between said particular organization and said payer organization for submission to a payer organization for payment" as recited in claim 17 of the present invention.

Additionally, even if the systems of Provost and Pritchard were combined, as suggested by the Rejection, the combined system would not make the present claimed invention unpatentable. The combined system would merely yield an interactive system for creating and submitting insurance claims and determining whether the claims are in condition for payment by an insurer. The combined system would include a client computer which establishes communication with a remote server. The combined system would also convert five digit service codes used to identify a service for reimbursement to four digit insurance carrier reimbursement codes. Unlike the present claimed invention which processes denial claim data AFTER billing and rejection/denial, the combined system of Provost and Pritchard occurs prior to billing. Furthermore, the combined system does not disclose or suggest "automatically adding a task to a task list of a worker comprising performing processing concerning said rejected claim data to derive corrected claim data including at least one (a) claim data supplemental to said rejected claim data and (b) amended rejected claim data, in response to said assigned selected internal activity code" as recited in claim 17 of the present invention. The combined system neither discloses nor suggests the use of an internal code set for automatically assigning the selected internal activity code to rejected claim data associated with the received notifications. The claimed feature of "automatically assigning said selected internal activity code to rejected claim data associated with said received notification," which is neither disclosed nor suggested by the combination, greatly improves claim processing.

Similarly, as described in the above with respect to Pritchard, the combined system of Pritchard and Provost converts a code into a service code which identifies a medical service that was already performed for a patient and NOT an activity to be performed in processing a claim denial/rejection, as in the present claimed invention. Therefore, the combined system of Provost and Pritchard neither discloses nor suggests "automatically adding a task to a task list of a worker comprising performing processing concerning said rejected claim data to derive

29

corrected claim data including at least one (a) claim data supplemental to said rejected claim data and (b) amended rejected claim data, in response to said assigned selected **internal** activity code" as recited in claim 17 of the present invention. Consequently, withdrawal of the rejection under 35 USC 103(a) is respectfully requested.

In view of the above remarks and amendments to the claims it is respectfully submitted that there is no USC 112 compliant enabling disclosure in Provost in view of Pritchard that makes claims 1, 14 and 17 unpatentable. As claim 2, 12 and 13 are dependent on claim 1 and claim 16 is dependent on claim 14, it is respectfully submitted that these claims are allowable for the same reasons as discussed above regarding claims 1 and 14. It is thus further respectfully submitted that this rejection is satisfied and should be withdrawn.

Rejection of Claims 3-5 and 15 under 35 U.S.C. 103(a) over Provost et al. (U.S. Patent No. 6,341,265) in view of Giannini (U.S. Patent No. 5,915,241), and further in view of Pritchard (U.S. Patent No. 4,491,725)

Reversal of the rejection of claims 3-5 and 15 under 35 U.S.C. 103(a) as being unpatentable over Provost et al. (U.S. Patent No. 6,341,265) in view of Giannini (U.S. Patent No. 5,915,241), and further in view of Pritchard (U.S. Patent No. 4,491,725) is respectfully requested because the rejection makes crucial errors in interpreting the cited reference. The rejection erroneously states that claims 3-5 and 15 are made unpatentable by Provost in view of Giannini and further in view of Pritchard.

CLAIM 3

Claim 3 is dependent on independent claim 1 and is considered patentable for the reasons presented above with respect to claim 1. Claim 3 is also considered patentable because Provost (with Giannini and Pritchard) neither discloses nor suggests the use of an "internal activity code" that is selected from a "predetermined internal activity code set." As discussed above, Provost with Pritchard provides no 35 USC 112 compliant enabling disclosure of an "internal activity code" that is "set to a specific organization" as in the present claimed invention.

Giannini describes a system to "standardize, encode and process healthcare provider billing" by "encoding, describing and processing fee charges for specific procedures of **non-conventional medicine**" (col. 1, lines 13-22). Giannini is concerned with attempting to correlate and accurately describe alternative medical procedures into data that can be provided to conventional payer organizations (e.g. insurance companies) to increase the likelihood that the claims for these non-conventional medical procedures will be paid (col. 1, lines 23-45). Thus, the Giannini system is wholly unlike the present claimed system which

"processes claim data for reimbursement of provision of healthcare **in response to rejection, denial, or lack of response to a submitted claim**". Unlike the present claimed system, Giannini provides a system for creating a claim and calculating payment amount for the claim based on a formula. Giannini (with Provost and Pritchard) is **not** concerned with "automatically scheduling a task comprising processing concerning rejected claim data to derive corrected claim data...in response to said assigned selected internal activity code" and "preparing said corrected claim data by including a standard activity code...different to said internal activity code set and facilitating compatible communication between said particular organization and a payer organization" as recited in the present claimed invention. The code employed by Giannini (with Provost and Pritchard) embodies the cost amount of a non-conventional medical procedure for communication with insurance companies. This is wholly unlike the present claimed invention which employs an "internal activity code" for automatic internal scheduling of a task and a "standard activity code" which ensure that the payer and payee (particular organization) are able to communicate with one another to facilitate collection of a claim that has been rejected or denied.

Applicant further respectfully submits that there is no reason or motivation to combine the system disclosed by Provost (with Pritchard) with the system disclosed by Giannini. Specifically, the Provost and Pritchard system provides for a pre-submission check of a claim for services by a remote system by comparing the diagnosis and treatment code **manually entered by a user** with additional information such as patient insurance information. If a claim is determined to be improper, the remote system notifies the client and the client can make further **manual** modifications to try to correct the claim. The manually corrected claim may contain patient treatment codes that are converted to insurance carrier service codes (see col. 6, lines 47-56 of Pritchard). The Giannini system, on the other hand, accesses multiple databases to identify, encode and calculate cost of a provider service (col. 4, lines 35-46). The combination of the Provost and Pritchard system and the Giannini system would be incompatible and produce an inoperable claim processing system. Since the Provost and Pritchard system will not accept a claim that will not be paid due to the comparison by the remote system, Provost and Pritchard would not be able to process and allow a claim having a code identifying non-conventional medical treatment that is not typically covered by the insurance plan of the patient. Thus, the Provost and Pritchard system and the Giannini system each accomplish distinct and unrelated objectives. Further, the distinct and unrelated objectives of Provost with Pritchard and Giannini are also unlike and unrelated to the objectives and operation of the present claimed invention.

Furthermore, even if one were able to combine the systems of Provost, Pritchard and Giannini, one would still not produce the present invention as claimed. Rather, the combined

system would be a claim pre-processing system that notifies a user if a submitted claim for either traditional or non-traditional medical treatment is in condition to be paid by analyzing diagnosis, treatment and an alternative billing code contained in the claim. The medical treatments would be assigned codes and the codes would be converted to insurance carrier service codes. Upon determining that the claim is not in condition for payment, a user would be notified to **manually** adjust the claim form for resubmission. This is wholly unlike the present claimed invention which provides a system and method for "processing claim data for reimbursement...in response to rejection, denial, or lack of response to a submitted claim." Provost, Pritchard or Giannini, when taken alone or in any combination, do not provide enabling disclosure of such a system. Instead, Provost with Pritchard and Giannini provide a system that attempts to prevent rejection or denial of a claim. Additionally, as discussed above, Provost (with Pritchard and Giannini) neither discloses nor suggests using "an internal activity code" to automatically schedule internal workflow processing intended "to derive corrected claim data." Provost and Pritchard with Giannini similarly provide no 35 USC 112 compliant enabling disclosure that the "corrected claim data" includes "a standard activity code from a standard activity code set different to said internal activity code set and facilitating compatible communication between said particular organization and a payer organization for submission to said payer organization for payment" as in the present claimed invention. Consequently, withdrawal of the rejection under 35 USC 103(a) is respectfully requested.

CLAIMS 4 and 5

Claim 4 is dependent on independent claim 1 and is considered patentable for the reasons presented above with respect to independent claim 1 and for the same reasons presented above to claim 3. Claim 4 is also considered patentable because Provost in view of Giannini in further view of Pritchard neither discloses nor suggests "receiving a nonpayment code of a nonpayment code set comprising at least one of, (a) a rejection code and (b) a denial code associated with said rejected claim data, and interpreting said received nonpayment code, translating said interpreted received nonpayment code to said standard activity code compatible with said standard activity code set" as recited in claim 4 of the present invention. Additionally, in the "Response to Arguments" section on page 20 of the Rejection, it is argued that Giannini fully supports the limitation of "translating said interpreted received nonpayment code to said standard activity code compatible with said standard activity code set" as recited in claim 4 of the present invention, "by showing a conversion table of Alternate Billing Code (i.e. nonpayment code) to specific RVU and conversion factor codes of a given insurance carrier. Based on the review of each table, the insurance carrier can correlate the conversion factor codes with the appropriate service code numbers (i.e. standard activity code, CPT) used by the insurance industry. (Giannini: col. 9, 61-col. 10, 11)" (Rejection, page 20). Applicant respectfully submits that although Giannini may convert codes for a particular insurance

carrier, Giannini (with Provost and Pritchard) does not disclose or suggest "receiving a nonpayment code of a nonpayment code set comprising at least one of, (a) a rejection code and (b) a denial code associated with said rejected claim data" as recited in claim 4 of the present invention. Consequently, Giannini (with Provost and Pritchard) **cannot** disclose or suggest "interpreting said received nonpayment code, translating said interpreted received nonpayment code to said standard activity code compatible with said standard activity code set" as recited in claim 4 of the present invention. As claim 5 is dependent on claim 4, claim 5 is also allowable for the same reasons as claim 4. Consequently, withdrawal of the rejection under 35 USC 103(a) is respectfully requested.

CLAIM 15

Claim 15 is dependent on independent claim 14 and is considered patentable for the reasons presented above with respect to claim 14. Claim 15 is also considered patentable because Provost (with Giannini and Pritchard) neither discloses nor suggests that the "identified nonpayment code comprises at least one of, (i) a rejection code and (ii) a denial code associated with said particular claim data, and said selecting step comprises interpreting said identified nonpayment code to determine, from said predetermined internal activity code set, an internal activity code compatible with said nonpayment code" as recited in claim 15 of the present invention.

Giannini describes a system to "standardize, encode and process healthcare provider billing" by "encoding, describing and processing fee charges for specific procedures of **non-conventional medicine**" (col. 1, lines 13-22). Giannini is concerned with attempting to correlate and accurately describe alternative medical procedures into data that can be provided to conventional payer organizations (e.g. insurance companies) to increase the likelihood that the claims for these non-conventional medical procedures will be paid (col. 1, lines 23-45). Thus, the Giannini system is wholly unlike the present claimed system in which "said identified nonpayment code comprises at least one of, (i) a **rejection code** and (ii) a **denial code** associated with said particular claim data." Unlike the present claimed system, Giannini provides a system for creating a claim and calculating payment amount for the claim based on a formula. Additionally, Giannini (with Provost and Pritchard) is **not** concerned with "interpreting said identified nonpayment code to determine, from said predetermined internal activity code set, an internal activity code compatible with said nonpayment code" as recited in claim 15 of the present invention. The code employed by Giannini (with Provost and Pritchard) embodies the cost amount of a non-conventional medical procedure for communication with insurance companies. This is wholly unlike the present claimed invention which determines, "from said predetermined internal activity code set, **an internal**

activity code compatible with said nonpayment code" as recited in claim 15 of the present invention.

Applicant further respectfully submits that there is no reason or motivation to combine the system disclosed by Provost (with Pritchard) with the system disclosed by Giannini. Specifically, the Provost and Pritchard system provides for a pre-submission check of a claim for services by a remote system by comparing the diagnosis and treatment code **manually entered by a user** with additional information such as patient insurance information. If a claim is determined to be improper, the remote system notifies the client and the client can make further **manual** modifications to try to correct the claim. The manually corrected claim may contain patient treatment codes that are converted to insurance carrier service codes (see col. 6, lines 47-56 of Pritchard). The Giannini system, on the other hand, accesses multiple databases to identify, encode and calculate cost of a provider service (col. 4, lines 35-46). The combination of the Provost and Pritchard system and the Giannini system would be incompatible and produce an inoperable claim processing system. Since the Provost and Pritchard system will not accept a claim that will not be paid due to the comparison by the remote system, Provost and Pritchard would not be able to process and allow a claim having a code identifying non-conventional medical treatment that is not typically covered by the insurance plan of the patient. Thus, the Provost and Pritchard system and the Giannini system each accomplish distinct and unrelated objectives. Further, the distinct and unrelated objectives of Provost with Pritchard and Giannini are also unlike and unrelated to the objectives and operation of the present claimed invention.

Furthermore, even if one were able to combine the systems of Provost, Pritchard and Giannini, one would still not produce the present invention as claimed. Rather, the combined system would be a claim pre-processing system that notifies a user if a submitted claim for either traditional or non-traditional medical treatment is in condition to be paid by analyzing diagnosis, treatment and an alternative billing code contained in the claim. The medical treatments would be assigned codes and the codes would be converted to insurance carrier service codes. Upon determining that the claim is not in condition for payment, a user would be notified to manually adjust the claim form for resubmission. However, the combined system would not disclose or suggest that the "identified payment code comprises at least one of, (i) a rejection code and (ii) a denial code associated with said particular claim data" as recited in claim 15 of the present invention. Additionally, as discussed above, Provost (with Pritchard and Giannini) neither discloses nor suggests using "an **internal activity code**" at all, and therefore, the combined system of Provost, Pritchard and Giannini cannot disclose or suggest "an internal activity code compatible with said nonpayment code" as recited in claim

15 of the present invention. Consequently, withdrawal of the rejection under 35 USC 103(a) is respectfully requested.

In view of the above remarks, Applicant respectfully submits that there is no 35 USC 112 compliant enabling disclosure present in Provost, Pritchard and Giannini, when taken alone or in any combination, that makes the present invention unpatentable. It is respectfully submitted that this rejection is satisfied and should be withdrawn.

Rejection of Claims 6-11 under 35 U.S.C. 103(a) over Provost et al. (U.S. Patent No. 6,341,265) in view of Diamant et al. (U.S. Patent No. 5,530,861), and further in view of Pritchard (U.S. Patent No. 4,491,725)

Reversal of the rejection of claims 6-11 under 35 U.S.C. 103(a) as being unpatentable over Provost et al. (U.S. Patent No. 6,341,265) in view of Diamant et al. (U.S. Patent No. 5,530,861), and further in view of Pritchard (U.S. Patent No. 4,491,725) is respectfully requested because the rejection makes crucial errors in interpreting the cited reference. The rejection erroneously states that claims 6-11 are made unpatentable by Provost in view of Diamant and further in view of Pritchard.

CLAIMS 6-11

Claims 6-11 are dependent on independent claim 1 and are considered patentable for the reasons presented above with respect to claim 1. Claims 6-11 are also considered patentable because Provost with Diamant and Pritchard neither disclose nor suggest using "an internal activity code" to automatically schedule internal workflow processing intended "to derive corrected claim data." Provost with Diamant and Pritchard similarly provides no 35 USC 112 compliant enabling disclosure that the "corrected claim data" includes "a standard activity code from a standard activity code set different to said internal activity code set and facilitating compatible communication between said particular organization and a payer organization for submission to said payer organization for payment" as in the present claimed invention.

Diamant discloses an automatic task management system for performing project tasks (see Abstract). Applicant respectfully submits that there is no motivation to combine the system disclosed by Diamant with the system disclosed by Provost in view of Pritchard because there is no enabling disclosure in Provost in view of Pritchard for automatic task management. Rather, the Provost and Pritchard combination requires a user **manually enter codes** which are then checked to determine if an insurance claim is in proper form for payment prior to submission. If the claim is not in proper form, the user is notified to

manually adjust the claim form based on suggestions presented by a remote system. The patient treatment codes that are contained within the form are converted to insurance carrier service codes (see col. 6, lines 47-56 of Pritchard). Thus, there is no 35 USC 112 compliant enabling disclosure in the Provost and Pritchard combined system to modify the combined system with the automated task management system of Diamant. Additionally, these systems are non-analogous art and one skilled in the art would not seek to combine an insurance claim pre-processing system as taught by Provost in view of Pritchard with an automatic task management system as taught by Diamant.

Furthermore, if one were to combine these systems, the resultant system would not include a system and method for "processing claim data for reimbursement of provision of healthcare to a patient in response to rejection, denial or lack of response to a submitted claim" as in the present claimed invention. In fact, in view of the remarks above with respect to claim 1, the Provost (and Pritchard) system would not allow a claim through unless it was in proper form and would not need to employ the features of the claimed arrangement to obtain insurance reimbursement. Thus, Provost (with Pritchard and Diamant) neither discloses nor suggests using "an internal activity code" to automatically schedule internal workflow processing intended "to derive corrected claim data." Provost with Diamant and Pritchard similarly provide no 35 USC 112 compliant enabling disclosure that the "corrected claim data" includes "a standard activity code from a standard activity code set different to said internal activity code set and facilitating compatible communication between said particular organization and a payer organization for submission to said payer organization for payment" as recited in the present claimed invention.

In view of the above remarks and amendments to the claims it is respectfully submitted that Provost and Diamant and Pritchard provides no 35 USC 112 compliant enabling disclosure that makes claim 1 unpatentable. As claim 6-11 are dependent on claim 1, it is respectfully submitted that these claims are allowable for the same reasons as discussed above regarding claim 1. It is thus further respectfully submitted that this rejection is satisfied and should be withdrawn.

VIII   CONCLUSION

Provost, when taken alone or in any combination with Pritchard, Giannini and Diamant, neither discloses nor suggests "processing claim data for reimbursement of provision of healthcare to a patient in response to rejection, denial, or lack of response to a submitted claim, comprising the steps of: automatically selecting an internal activity code from a predetermined internal activity code set specific to a particular organization and including a plurality of codes identifying processing to be performed concerning rejected

36

claim data in response to a received notification of claim denial or rejection... automatically scheduling a task comprising performing processing concerning said rejected claim data to derive corrected claim data including at least one (a) claim data supplemental to said rejected claim data and (b) amended rejected claim data, in response to said assigned selected internal activity code" as recited in claim 1 of the present invention. Additionally, Provost with Pritchard, Giannini and Diamant also neither discloses nor suggests "preparing said corrected claim data by including a standard activity code from a standard activity code set different to said internal activity code set and facilitating compatible communication between said particular organization and a payer organization for submission to said payer organization for payment" as recited in claim 1 of the present invention. As independent claims 1, 14 and 17 all contain similar features, these claims are all allowable. Furthermore, as claims 2-13 and 15-16 are dependent on claims 1 and 14, respectively, these claims are also allowable over Provost, Pritchard, Giannini and Diamant, when taken in any combination.

Accordingly it is respectfully submitted that the rejection of Claims 1-17 should be reversed.

Respectfully submitted,

Alexander J. Burke
Reg. No. 40,425

Date: October 2, 2007

Alexander J. Burke
Intellectual Property Department
Siemens Corporation,
170 Wood Avenue South
Iselin, N.J. 08830
Tel. 732 321 3023
Fax 732 321 3030

APPENDIX 1 - APPEALED CLAIMS

1. (Previously Presented) A method for processing claim data for reimbursement of provision of healthcare to a patient in response to rejection, denial, or lack of response to a submitted claim, comprising the steps of:

automatically selecting an internal activity code from a predetermined internal activity code set specific to a particular organization and including a plurality of codes identifying processing to be performed concerning rejected claim data in response to a received notification of claim denial or rejection;

automatically assigning said selected internal activity code to rejected claim data associated with said received notification;

automatically scheduling a task comprising performing processing concerning said rejected claim data to derive corrected claim data including at least one (a) claim data supplemental to said rejected claim data and (b) amended rejected claim data, in response to said assigned selected internal activity code; and

preparing said corrected claim data by including a standard activity code from a standard activity code set different to said internal activity code set and facilitating compatible communication between said particular organization and a payer organization for submission to said payer organization for payment.

2. (Previously Presented) A method according to claim 1, wherein

said predetermined internal activity code set is different from a set of codes identifying a nonpayment reason associated with said rejected claim data comprising at least one of, (a) a rejection reason, (b) a rejection activity code representing the rejection reason, (c) a denial reason, and (d) a denial activity code representing the denial reason.

3. (Previously Presented) A method according to claim 1, including the step of

receiving a nonpayment code comprising at least one of, (a) a rejection code and (b) a denial code associated with said rejected claim data, and

said selecting step comprises interpreting said received nonpayment code to determine, from said predetermined internal activity code set, an internal activity code compatible with said nonpayment code.

4. (Previously Presented) A method according to claim 1, including the steps of

receiving a nonpayment code of a nonpayment code set comprising at least one of, (a) a rejection code and (b) a denial code associated with said rejected claim data, and

interpreting said received nonpayment code,

translating said interpreted received nonpayment code to said standard activity code compatible with said standard activity code set.

5. (Previously Presented) A method according to claim 4, including the step of

translating said interpreted received nonpayment code to an internal activity code wherein

said internal activity code set comprises fewer codes than said predetermined nonpayment code set.

6. (Original) A method according to claim 1, including the step of

assigning a time and date identifier to rejected claim data associated with said received notification, said identifier indicating a time and date indicative of at least one of, (a) a time and date associated with scheduling a task comprising performing processing concerning said rejected claim data, (b) a time and date associated with processing said received notification of claim denial or rejection, (c) a time and date associated with receiving notification of claim denial or rejection and (d) a time and date identifying expiration of a period assigned to complete performance of said processing concerning said rejected claim data.

7. (Original) A method according to claim 1, including the steps of

assigning a time and date identifying expiration of a period assigned to complete performance of said processing concerning said rejected claim data and

initiating generation of a message alerting a user to at least one of, (a) said period is due to expire at said time and date and (b) said period has expired.

8. (Original) A method according to claim 1, wherein

said method is used to provide corrected claim data for a plurality of rejected claims in response to a corresponding plurality of received notifications of claim denial or rejection and including the step of

collating data concerning said rejected claims by at least one of, (a) payer organization associated with said notification and (b) reason for claim rejection or denial derived from said notification.

9. (Previously Presented) A method according to claim 1, wherein

said method is used to provide corrected claim data for a plurality of rejected claims in response to a corresponding plurality of received notifications and including the step of

automatically collating rejected claim data by at least one of, (a) payer organization associated with said notification, (b) assigned activity code and (c) type of request for information indicated in a corresponding notification.

10. (Original) A method according to claim 1, including the step of

acquiring statistics concerning at least one of, (a) type and frequency of claim rejections, (b) type and frequency of claim denials, (c) data identifying success rate of first time claims submissions for an individual payer, (d) data indicating a time duration expected for processing of a submitted claim for an individual payer, (e) data indicating a time duration expected for processing a non-paid claim until re-submission and (f) data identifying a proportion of non-recoverable claims for an individual payer.

11. (Original) A method according to claim 10, including the step of

employing said statistics to at least one of, (i) modify processing of said rejected claim data and (ii) create a statistical report for an individual payer.

12. (Previously Presented) A method according to claim 1, including the step of

determining from said notification whether said rejected claim data was accompanied by a denial or rejection notification and wherein

said selecting step comprises selecting a first internal activity code in response to a denial notification and a different second internal activity code in response to a rejection notification.

13. (Original) A method according to claim 1, wherein

said method steps are performed automatically and at least one of, (a) excluding manual intervention and (b) employing partial manual intervention by one or more healthcare workers.

14. (Previously Presented) A method for processing claim data for reimbursement of provision of healthcare to a patient in response to rejection, denial, or lack of response to a submitted claim, comprising the steps of:

identifying a nonpayment code, associated with a predetermined nonpayment code set, from a received notification of claim nonpayment associated with particular claim data;

automatically selecting an internal activity code from a predetermined internal activity code set including a plurality of codes specific to a particular organization and identifying processing to be performed concerning non-paid claim data in response to said identified nonpayment reason;

automatically assigning said selected internal activity code to said particular claim data associated with said received notification;

automatically adding a task to a task list of a worker comprising performing processing concerning said particular claim data to derive corrected claim data including at least one (a) claim data supplemental to said rejected claim data and (b) amended rejected claim data, in response to said assigned selected internal activity code; and

preparing said corrected claim data by including a standard activity code from a standard activity code set different to said internal activity code set and facilitating compatible communication between said particular organization and a payer organization for submission to said payer organization for payment.

15. (Previously Presented) A method according to claim 14, wherein

said identified nonpayment code comprises at least one of, (i) a rejection code and (ii) a denial code associated with said particular claim data, and

said selecting step comprises interpreting said identified nonpayment code to determine, from said predetermined internal activity code set, an internal activity code compatible with said nonpayment code.

16. (Original) A method according to claim 14, wherein

said predetermined nonpayment code set is compatible with a HIPAA standard code set.

17. (Previously Presented) A system for processing claim data for reimbursement of provision of healthcare to a patient in response to rejection, denial, or lack of response to a submitted claim, comprising:

a workflow processor for,

automatically selecting an internal activity code from a predetermined internal activity code set specific to a particular organization and including a plurality of codes

identifying processing to be performed concerning rejected claim data in response to a received notification of claim denial or rejection;

automatically assigning said selected internal activity code to rejected claim data associated with said received notification;

automatically adding a task to a task list of a worker comprising performing processing concerning said rejected claim data to derive corrected claim data including at least one (a) claim data supplemental to said rejected claim data and (b) amended rejected claim data, in response to said assigned selected internal activity code; and

an interface processor for preparing said corrected claim data by including a standard activity code from a standard activity code set different to said internal activity code set and facilitating compatible communication between said particular organization and said payer organization for submission to a payer organization for payment.

APPENDIX II - EVIDENCE

Applicant does not rely on any additional evidence other than the arguments submitted hereinabove.

APPENDIX III - RELATED PROCEEDINGS

Applicant respectfully submits that there are no proceedings related to this appeal in which any decisions were rendered.

APPENDIX IV - TABLE OF CASES

1.   *In re Howard*, 394 F. 2d 869, 157 USPQ 615, 616 (CCPA 1968)

2.   29 AM. Jur 2D Evidence S. 33 (1994)

3.   *In re Ahlert*, 424 F. 2d 1088, 1091, 165 USPQ 418, 420 (CCPA 1970)

4.   *In re Eynde*, 480 F. 2d 1364, 1370; 178 USPQ 470, 474 (CCPA 1973)

5.   *In re Fine*, 5 USPQ 2d 1600, (Fed Cir. 1988)

6.   ACS Hospital Systems Inc v. Montefiore Hospital, 221 USPQ 929,933
        (Fed. Cir. 1984)

7.   *Graham v. John Deere Co.*, 383 U.S. 1, 17, 148 USPQ 459, 467 (CCPA 1966)

8.   *Uniroyal, Inc. v. Rudkin-Wiley Corp.*, 837 F.2d 1044, 1051, 5 USPQ2d 1434, 1438
        (Fed.Cir. 1988), *cert. denied*, 488 U.S. 825 (1988)

9.   *Ashland Oil Inc. v. Delta Resins & Refractories, Inc.*, 776 F.2d 28, 293, 227 USPQ
        657, 664 (Fed.Cir. 1985), *cert. denied*, 475 U.S. 1017 (1986)

10.   *In re Oetiker*, 977 F2d 1443, 1445, 24 USPQ2d 1443, 1444 (Fed. Cir. 1992)

APPENDIX V - LIST OF REFERENCES

U.S. Patent No.	Issued Date	102(e) Date	Inventors
6,341,265	January 22, 2002		Provost et al.
4,491,725	January 1, 1985		Pritchard
5,530,861	June 25, 1996		Diamant et al.
5,915,241	June 22, 1999		Giannini

TABLE OF CONTENTS